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## **Executive summary**

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By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Medicare Part D). In this year's report, we:

- consider the context of the Medicare program, including the near-term consequences of the coronavirus pandemic and the longer-term effects of program spending on the federal budget and the program's financial sustainability.
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2022 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health agency, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- as mandated by the Congress, report on the expansion of the hospital post-acute care transfer policy to hospice.
- review the status of the MA program (Medicare Part C) through which beneficiaries can join private plans in lieu of traditional FFS Medicare.
- review the status of the Medicare program that provides prescription drug coverage (Medicare Part D).
- present an option for Medicare's coverage of telehealth services after the coronavirus public health emergency (PHE).

In 2020, the global coronavirus pandemic had catastrophic consequences for many Medicare beneficiaries and affected health care delivery for all. In this report, we begin to discuss some of the effects of the pandemic, including on beneficiary access, mortality, and service use. We also begin to assess the effects on providers that are considered in this report. A fuller discussion of the pandemic's effects on beneficiaries and providers, including lessons learned, will require analysis of data that are still being collected and is beyond the scope of this report.

In this report, we recommend payment rate updates for nine FFS payment systems for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. Where relevant, we have considered the effects of the 2020 coronavirus PHE on our indicators and whether those effects are likely to be temporary or permanent. To the extent that the effects of the PHE are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary funding policies rather than a permanent change to payment rates in 2022 and future years.

The goal of Medicare payment policy is to obtain good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Payment system incentives that promote the efficient delivery of care serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums.

The Commission recognizes that managing updates and relative payment rates alone will not solve what have historically been fundamental problems with Medicare FFS payment systems—that providers are paid more when they deliver more services, often without regard to the value of those additional services, and that these payment systems seldom include incentives for providers to coordinate services over time and across care settings. To address these problems directly, two approaches must be pursued. First, payment reforms need to be implemented more broadly, coordinated across settings, and pursued as expeditiously as possible. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care need to be enhanced and closely monitored, and successful models need to be adopted on a broad scale.

In the interim, it is imperative that the current FFS payment systems be managed carefully and continuously improved. Medicare is likely to continue using its current FFS payment systems for some years into the future. This fact alone makes unit prices—their overall level, the relative prices of different services within a sector, and the relative prices of the same service across sectors—of critical importance. Constraining unit price increases can induce providers to control their own costs and to be more

receptive to new payment methods and delivery system reforms.

For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods. Unlike official budget estimates used to assess the impact of legislation, these estimates do not take into account the complete package of policy recommendations or the interactions among them. Although we include these budgetary implications, our recommendations are not driven by any single budget or financial performance target, but instead reflect our assessment of the payment rates needed to ensure adequate access to appropriate care while promoting the fiscal sustainability of the Medicare program.

In Appendix A, we list all recommendations and the Commissioners' votes.

### **Context for Medicare payment policy**

This year, as discussed in Chapter 1, both the short- and long-term contexts for the Medicare program are sobering. In the short term, the nation is in the midst of a historic coronavirus pandemic. Medicare beneficiaries are at particular risk. Those over 65 are more likely to suffer severe COVID-19 cases and complications and die than those who are younger and have fewer comorbidities. Beneficiaries in nursing facilities have accounted for a disproportionate share of fatalities from COVID-19. In addition, non-White Medicare beneficiaries have faced disproportionately high rates of mortality due to COVID-19, reflecting, in part, longstanding inequalities in the health care system and society. Providers are also under stress. The demands put on individual clinicians and other staff have been extreme. The financial stress on providers is unpredictable, although it has been alleviated to some extent by government assistance and rebounding service utilization levels.

The longer-term prospects for the program are daunting as well. The financial future of the Medicare program was already problematic, but as a result of job losses, in 2020 the Congressional Budget Office projected that Medicare's Hospital Insurance Trust Fund will become insolvent by 2024—two years earlier than previously expected. (Other, long-range projections in Chapter 1 do not yet reflect

the impact of the pandemic.) Driven by growth in the volume and intensity of services provided to beneficiaries and the number of beneficiaries aging into the program, Medicare's annual spending is projected to double in the 10-year period between 2019 and 2029, from \$782 billion to \$1.5 trillion. During this period, Medicare's share of total federal spending is expected to rise from 14.6 percent to 17.5 percent.

Increasing Medicare spending also strains beneficiaries' household budgets. In 2020, Medicare premiums and cost sharing were estimated to consume 24 percent of the average Social Security benefit, up from 14 percent in 2000. The Medicare Trustees estimate that in another 20 years, these costs will consume 31 percent of the average Social Security benefit.

One of the most powerful ways Medicare can control spending growth is by setting prices. Over the last 10 years, Medicare's spending per beneficiary has grown much more slowly than private health insurance spending per enrollee. Increasing prices were the main cause of health care spending growth for the privately insured. Price increases were driven by increases in provider market power as hospitals and physician groups consolidated. From 2009 to 2019, that consolidation contributed to average annual per enrollee growth in spending on private health insurance of 3.6 percent. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent annually—nearly the same as the general inflation rate of 1.8 percent over this period. This difference suggests that private plans' greater ability to constrain volume has less of an effect on spending than the Medicare program's greater ability to constrain prices under its administered pricing system.

Given Medicare's financing challenges, many believe that restraining price growth will not be enough to ensure Medicare's fiscal sustainability and that growth in the quantity of health care services must also be reduced. Medicare has piloted a number of alternative payment models that give providers incentives to more closely manage and coordinate beneficiaries' care to keep them healthy and reduce unnecessary service use. The ultimate goal of these payment models is to reduce growth in spending while maintaining or improving the quality of care.

Prices and utilization rates can also be influenced through other means. The Commission has identified a number

of aspects of Medicare payment systems that hamper the program's ability to achieve fiscal sustainability. The Commission has and will continue to make recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and equity without sacrificing quality or access.

## **Assessing payment adequacy and updating payments in fee-for-service Medicare**

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. As explained in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2021) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year; here, 2022). Finally, we make a judgment about what, if any, update is needed for the policy year in question.

To the extent that events create temporary shocks to the Medicare component of providers' finances, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' Medicare payment rates. Because payment updates are cumulative—that is, they compound each year—they are not the preferred policy response to abrupt but temporary changes in demand for health care or resulting health care spending. For example, the coronavirus pandemic changed the demand for and delivery of health care in 2020 and had material effects on providers' patient volume, revenues, and costs. Moreover, these effects have varied, and continue to vary widely, across different geographies, across different types of providers, and among individual providers. Although the effects are persisting in 2021, the Commission expects much of the pandemic's impact on health care will be temporary.

To fulfill our congressional mandate in regard to payment system updates, we must confine our focus to effects that we expect will impact payment adequacy in the given policy year. As noted above, to the extent the pandemic

effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies. Nonetheless, if there are changes during the PHE that have effects on providers' cost structures that we expect will persist into 2022 (the policy year for our recommendations), those changes are noted in each sector's payment adequacy discussion and will factor into our estimates of payment adequacy. We will monitor the impacts of COVID-19 over time, and any lasting effects will be considered as we evaluate the adequacy of Medicare payments in future years.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professional services, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. The Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years, using the most recent data available to make sure its recommendations accurately reflect current conditions. We use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022, accounting for anticipated changes in providers' costs between 2021 and 2022. Because of standard data lags, the most recent complete data we have are generally from 2019. The coronavirus PHE has created additional data lags, most notably for cost reports because the deadlines for their submission were extended. Where possible, we have bolstered our analyses with data from 2020, including interim claims data, information on facility closures, and beneficiary survey data.

In considering updates to payment rates, we may also recommend changes that redistribute payments within a payment system to correct any biases that may make treating patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. We may also make recommendations to improve program integrity where we deem it necessary. Our goal is to apply consistent criteria across settings, but because conditions at baseline and anticipated changes between baseline and the policy year may vary, the recommended updates may vary across sectors.

Our recommendations in this report, if adopted, could significantly change the revenues providers receive from



Medicare. Payment rates set to cover the costs of relatively efficient providers help induce all providers to control their costs. Furthermore, Medicare rates also have broader implications for health care spending because they are used in setting payments for other government programs and private health insurance. Thus, while setting prices intended to support efficient provision of care directly benefits the Medicare program, it can also help control health care spending across payers.

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services furnished in different settings. Basing the payment amount for these services on the rate paid in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the financial incentive to provide services in the higher paid setting.

### **Hospital inpatient and outpatient services**

Short-term acute care hospitals provide acute inpatient and outpatient services, such as treatments for acute medical conditions and injuries. Medicare's payment rates for inpatient and outpatient services are generally set under the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS). In 2019, payments under these hospital payment systems totaled \$186 billion. About 5.5 million beneficiaries had 8.7 million inpatient stays in the 3,200 acute care hospitals paid under the IPPS in 2019. That same year, 20.6 million beneficiaries made 97.1 million visits to the 3,700 hospitals providing outpatient services under the OPPS.

As described in Chapter 3, most of our payment adequacy indicators for hospital services are positive.

**Beneficiaries' access to care**—Our payment adequacy indicators suggest Medicare beneficiaries continue to have good access to hospital services. In 2019, the aggregate hospital occupancy rate was 64 percent, suggesting that hospitals have excess inpatient capacity in most markets. This capacity remains adequate despite an increase in hospital closures in 2019 that was partially driven by a decline in admissions per capita. Inpatient stays per capita continued their gradual decline in 2019 (falling 1.9 percent), while outpatient services per capita continued their slow increase (rising 0.7 percent). These trends reflect the continuing shift of care from inpatient to outpatient settings and from physician offices to hospital

outpatient departments (as hospitals acquire physician practices). Hospitals' marginal profit on Medicare FFS beneficiaries was about 8 percent in 2019, indicating that hospitals with excess capacity continue to have a financial incentive to serve additional Medicare beneficiaries.

**Quality of care**—In 2019, risk-adjusted readmission and mortality rates improved modestly, and patient experience measures remained stable. In March 2019, the Commission recommended a redesign of the current hospital quality payment programs, including removing the current penalty-only quality programs and enacting a new hospital value incentive program (HVIP) that balances rewards and penalties and has the potential to drive further improvement in hospital quality.

**Providers' access to capital**—Hospitals had record high all-payer operating and total margins, which contributed to strong access to capital in 2019. Furthermore, hospital construction spending held steady, municipal bond interest rates remained low, hospital mergers and acquisitions continued, and hospital employment remained stable.

**Medicare payments and providers' costs**—Medicare's payments to IPPS hospitals grew faster than hospitals' costs in 2019, resulting in the aggregate Medicare margin increasing slightly from –9.3 to –8.7 percent among all IPPS hospitals, and the median margin increasing from about –2 percent to –1 percent for relatively efficient hospitals. Hospitals' Medicare margins increased primarily because Medicare made an additional \$1.5 billion in payments to hospitals to help cover the costs of charity care and non-Medicare bad debts.

While the coronavirus PHE has made 2020 an anomalous year in many respects and it is impossible to predict with certainty the extent to which these effects will continue into 2021, we expect IPPS hospitals' Medicare margin to increase to about –6 percent in 2021, driven by substantially higher payment rate updates than in 2019 and prior years and by the suspension of Medicare sequestration through the first half of fiscal year 2021. We also expect the efficient providers' Medicare margin will improve in 2021 to become slightly positive. The exact increase in the Medicare margin will depend in large part on the duration and severity of the coronavirus pandemic, volume changes, case-mix changes, and changes in costs relative to input price inflation, as well as any additional payment or other policy changes enacted during the pandemic.

On the basis of generally positive payment adequacy indicators, the Commission recommends that the Congress, for 2022, update the 2021 Medicare base payment rates for acute care hospitals by 2 percent. Together with the statutory additional 0.5 percent increase to inpatient payments and the 0.8 percent increase to inpatient payments from our standing recommendation to replace the current quality program penalties with the HVIP, on net, inpatient payments would increase by 3.3 percent and outpatient payment rates would increase by 2.0 percent. The 2 percent outpatient update (rather than the 2.4 percent estimated under current law) would limit growth in the differential between rates paid for physician office visits on a hospital campus and rates paid for those visits at freestanding physician offices.

### **Mandated report: Expanding the post-acute care transfer policy to hospice**

In Chapter 3, we also report on the effects of expanding the post-acute care transfer policy to hospices, as mandated by the Balanced Budget Act of 2018. Under the post-acute care transfer policy, when Medicare beneficiaries with certain conditions have short inpatient stays and are transferred to a post-acute care setting, the transferring hospital receives a per diem payment rather than the full IPPS amount. The Bipartisan Budget Act of 2018 expanded the IPPS post-acute care transfer policy to include hospital transfers to hospice beginning in fiscal year 2019 and mandated that the Commission evaluate and report on the effects of this policy change. We estimate that the policy change resulted in savings of about \$304 million in fiscal year 2019 and about \$78 million in the first quarter of fiscal year 2020, without any discernable changes in Medicare beneficiaries' timely access to hospice care.

### **Physician and other health professional services**

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. Medicare pays for these clinician services using a fee schedule. In 2019, Medicare paid \$73.5 billion for clinician services, accounting for just under 18 percent of traditional FFS Medicare spending. In the same year, almost 1.3 million clinicians billed the fee schedule, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

As described in Chapter 4, our payment adequacy indicators for clinician services are positive.

***Beneficiaries' access to care***—Overall, beneficiary access to clinician services is comparable with prior years, despite the current PHE. Consistent with prior years, most beneficiaries continued to report that they are able to find a new doctor without a problem, and the vast majority of beneficiaries reported being satisfied with their care, having a usual source of care, and having no trouble accessing timely care. From 2014 to 2019, the number of clinicians billing the fee schedule grew faster than the number of Medicare beneficiaries, with a slight decrease in the number of primary care physicians more than offset by rapid growth in the number of advanced practice registered nurses and physician assistants. The number of clinician encounters per beneficiary increased modestly from 2018 to 2019.

***Quality of care***—Geographic variation in traditional Medicare beneficiaries' ambulatory care—sensitive hospitalizations and emergency department visits signals opportunities to improve the quality of ambulatory care. There is also substantial use of low-value care among Medicare beneficiaries. (Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.) We estimate that, in 2018, between 22 percent and 36 percent of beneficiaries in traditional FFS Medicare received at least one low-value service, and Medicare spending for these services ranged from \$2.4 billion to \$6.9 billion.

***Medicare payments and providers' costs***—Clinicians' Medicare payments and input costs continue to rise. Between 2018 and 2019, traditional Medicare's allowed charges (i.e., payments to providers, including beneficiary cost sharing) for clinician services per beneficiary grew 3.7 percent, a higher growth rate than in prior years. In 2019, private insurance payment rates for clinician services were 136 percent of traditional FFS Medicare's rates, compared with 135 percent in 2018. From 2015 to 2019, median physician compensation from all payers grew by 3.3 percent per year, on average. However, median compensation in 2019 remained much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties—underscoring concerns about the mispricing of fee schedule services and its impact on primary care. Effective January 1, 2021, CMS increased payment rates

for evaluation and management office/outpatient visits and reduced rates for many other services, which should help address the compensation gap between primary care physicians and certain specialists. CMS projects that clinician input costs—as measured by the Medicare Economic Index—will increase by 1.6 percent in 2022.

Under current law, there is no update to the Medicare fee schedule base payment rate for 2022. However, clinicians are eligible for performance-based payment adjustments or can receive an incentive payment worth 5 percent of their professional services payments if they participate in an advanced alternative payment model. The Commission's analyses suggest that Medicare's aggregate payments for clinicians are adequate. Therefore, the Commission's recommendation is that the Congress should update the 2022 Medicare payment rates for physician and other health professional services by the amount determined under current law.

### **Ambulatory surgical center services**

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. In 2019, the 5,816 ASCs that were certified by Medicare treated 3.5 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$5.2 billion.

As described in Chapter 5, our payment adequacy indicators for ASC services are positive.

**Beneficiaries' access to care**—Increasing growth in the supply of ASCs and the volume of ASC services indicates that beneficiaries' access to ASC services is adequate. From 2014 to 2018, the number of ASCs increased by an average annual rate of 1.7 percent. In 2019, the number of ASCs increased 2.5 percent. Most new ASCs in 2019 (96 percent) were for-profit facilities. From 2014 through 2018, the volume of services per Part B fee-for-service beneficiary increased by an average annual rate of 2.1 percent. In 2019, volume increased by 2.7 percent.

**Quality of care**—Among the eight quality measures in the ASC Quality Reporting (ASCQR) Program for which data were available for multiple years through 2018, performance among the ASCs that reported data improved for most measures from 2013 through 2017, but from 2017 to 2018 the measures were largely unchanged and decreased for one measure. For 2019 and beyond, CMS has been making several changes to the ASCQR Program.

However, we remain concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems® measures, the lack of a value-based purchasing program for the ASC sector, and the lack of claims-based outcome measures that apply to all ASCs.

**Providers' access to capital**—Because the number of ASCs—especially for-profit ASCs—has continued to increase and consolidation in the ASC market has maintained a steady pace, access to capital appears to be adequate.

**Medicare payments and providers' costs**—ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy. From 2014 through 2018, Medicare payments for ASC services per FFS beneficiary increased by an average annual rate of 5.8 percent. However, in 2019, growth in these payments increased by 8.3 percent.

On the basis of these positive payment adequacy indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services and recommends no update to the payment rates for 2022. In addition, because the Commission believes cost data are vital for making informed decisions about updating ASC payment rates and for identifying an appropriate input price index for ASCs, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay.

### **Outpatient dialysis services**

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2019, nearly 395,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from nearly 7,700 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services based on a PPS bundle that includes certain ESRD-related drugs and clinical laboratory tests that were previously paid separately. In 2019, Medicare expenditures for outpatient dialysis services were \$12.9 billion.

As described in Chapter 6, our payment adequacy indicators for dialysis services are generally positive.

**Beneficiaries' access to care**—Growth in the capacity of dialysis facilities and their continued financial incentive



to treat additional Medicare FFS beneficiaries indicate that beneficiaries' access to dialysis services has been adequate. Between 2018 and 2019, the number of dialysis treatment stations grew faster than the number of FFS dialysis beneficiaries (but kept pace with demand from all dialysis patients). During this same time period, growth in the number of FFS dialysis beneficiaries matched growth in the total number of treatments. At the same time, use of ESRD drugs in the bundle continued to decline, but at a slower rate than during the initial years of the ESRD PPS (2011 and 2012). In 2019, dialysis facilities' marginal profit was 25 percent, indicating that providers have a financial incentive to continue to serve Medicare beneficiaries.

**Quality of care**—Between 2014 and 2019, hospitalization, hospital readmission, and mortality rates remained steady, though the proportion of FFS dialysis beneficiaries using the emergency department slightly increased. Between 2014 and 2019, the share of beneficiaries using home dialysis, which is associated with better patient satisfaction, increased.

**Providers' access to capital**—Information from investment analysts suggests that access to capital for dialysis providers continues to be strong. The number of facilities, particularly for-profit facilities, continues to increase. Under the ESRD PPS, the two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations.

**Medicare payments and providers' costs**—Medicare's payments to freestanding dialysis facilities have increased faster than their costs. From 2018 to 2019, cost per treatment fell by 4 percent, while Medicare payment per treatment rose by 2 percent, and the aggregate Medicare margin increased from 2.1 percent to 8.4 percent. We project the 2021 Medicare margin will drop to 4 percent, in part due to CMS including calcimimetics in the ESRD PPS bundled payment, which will promote provider efficiency.

Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.5 percent. On the basis of the positive payment adequacy indicators, the Commission recommends that, for 2022, the Congress eliminate the update to the 2021 ESRD PPS base rate.

## Skilled nursing facility services

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to Medicare

beneficiaries after a stay in an acute care hospital. In 2019, about 15,000 SNFs furnished about 2 million Medicare-covered stays to 1.5 million FFS beneficiaries, and Medicare FFS spending on SNF services was \$27.8 billion.

As described in Chapter 7, most of our payment adequacy indicators, which are based on the most recent complete data that we have, are positive. That said, we recognize that nursing homes have been particularly hard hit by the coronavirus pandemic and the associated PHE. As devastating as the pandemic's effects have been, we expect the industry to eventually recover, though its recovery may be sluggish and will vary by provider and market.

**Beneficiaries' access to care**—Before the PHE, access to SNF services was adequate for most beneficiaries. The number of SNFs participating in the Medicare program has been stable for many years. In 2019, the vast majority (90 percent) of beneficiaries lived in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). Between 2018 and 2019, the median occupancy rate declined slightly but remained high (about 85 percent). During the PHE, occupancy declined more than 10 percentage points, but this decline is unrelated to the adequacy of Medicare's payments. Consistent with the slight decline in SNF occupancy observed in 2019, Medicare-covered admissions per 1,000 FFS beneficiaries decreased 4.8 percent, similar to a decrease in the number of admissions for hospital stays that lasted at least three days (required for Medicare coverage). Freestanding SNFs had an average marginal profit of almost 20 percent in 2019, indicating that freestanding SNFs have a financial incentive to treat additional Medicare FFS beneficiaries.

**Quality of care**—Since 2015, rates of successful discharge to the community have increased and hospitalizations within a stay have decreased. These positive trends continued from 2018 to 2019.

**Providers' access to capital**—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Before the PHE, access to capital was adequate, and though lending activity has stalled during the PHE, it is expected to be good in 2021. In 2019, the total margin (a measure of the total financial performance across all payers and lines of business for the facility) was 0.6 percent. Any lending wariness reflects broad changes in

post-acute care, not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

**Medicare payments and providers' costs**—Consistently high average Medicare margins indicate that Medicare FFS payments have continued to exceed freestanding SNFs' average costs. In 2019, the average Medicare margin for freestanding SNFs was 11.3 percent. Since 2000, the average Medicare margin has been above 10 percent, and the very high Medicare margin (19.2 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care. MA plans' payment rates, considered attractive by many SNFs, are much lower than the program's FFS payments and are unlikely to be explained by the differences in patient characteristics between SNF users enrolled in MA and those in FFS. In 2021, providers are likely to incur higher costs associated with post-PHE changes in practices (e.g., higher expenditures for personal protective equipment and testing). We also expect Medicare volume to not fully recover to pre-PHE levels, at least in the near term. Providers will also continue to adjust their practices to the new case-mix system that was implemented on October 1, 2019. We project the aggregate Medicare margin to be about 10 percent in 2021.

On the basis of these positive payment adequacy indicators, the Commission recommends that, for fiscal year 2022, the Congress eliminate the update to the fiscal year 2021 Medicare base payment rates for SNFs. While the projected level of payments indicates that payments need to be reduced to more closely align aggregate payments and costs, the lasting impacts of COVID-19 on SNFs and the effects of the new case-mix system are uncertain. Because the SNF industry is likely to undergo considerable changes as it adjusts to both, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low.

## Medicaid trends

As required by the Affordable Care Act, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes, but it also covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF.

Between 2019 and 2020, the number of Medicaid-certified facilities declined less than 1 percent, to 14,784. Spending was \$39 billion in 2019, about 5 percent less than in 2018.

In 2019, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as skilled and long-term care, hospice, ancillary services, home health care, and investment income)—was 0.6 percent, an increase from 2018. The average non-Medicare margin (which includes all payers and all lines of business except FFS Medicare SNF services) was –2 percent, also an improvement from 2018.

## Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2019, about 3.3 million Medicare FFS beneficiaries received care, and the program spent \$17.8 billion on home health care services. In that year, over 11,300 HHAs participated in Medicare.

As described in Chapter 8, our payment adequacy indicators for home health care services are generally positive.

**Beneficiaries' access to care**—Medicare FFS beneficiaries' access to home health care has been adequate. In 2019, over 99 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated, and 86 percent lived in a ZIP code with five or more HHAs. In 2019, the number of HHAs declined by 1.7 percent, continuing a slow decline since 2013. However, the decline follows a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by over 80 percent. The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years. Similarly, in 2019 the number of 60-day episodes declined by 3.0 percent, continuing a slight decline that began in 2011. While home health care episodes have decreased somewhat, freestanding HHAs' marginal profit on Medicare patients in 2019 was 18 percent, suggesting that HHAs have a significant financial incentive to treat additional Medicare beneficiaries.

**Quality of care**—In 2019, our outcome measures were mixed. The rate of home health patients who were hospitalized during their spell of home health services increased slightly, but the share who were successfully discharged to the community (patients who did not experience an unplanned hospitalization within 30 days of

the end of their spell of home health care) also increased slightly.

**Providers' access to capital**—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs.

**Medicare payments and providers' costs**—For more than a decade, payments under the home health PPS have consistently and substantially exceeded costs. In 2019, Medicare spending for home health care declined by 0.5 percent, but Medicare margins for freestanding agencies averaged 15.8 percent. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by decreasing the number of visits provided, and cost growth in recent years has been lower than the annual payment updates for home health care. Though the PHE was a disruption for HHAs, the emergency has not significantly changed the financial outlook or service delivery practices of the industry. The Commission projects that Medicare margins for freestanding HHAs in 2021 will be 14 percent.

Overpayments for home health care services diminish the value of the services as a substitute for more costly ones. Given the positive payment adequacy indicators, for 2022 the Commission recommends a 5 percent reduction in the Medicare home health PPS base payment rate.

## **Inpatient rehabilitation facility services**

Inpatient rehabilitation facilities (IRFs) are hospitals or distinct units of hospitals that provide medical care as well as intensive rehabilitation programs to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech-language pathology, and prosthetic and orthotic services. In 2019, Medicare spent \$8.7 billion on IRF care. About 363,000 beneficiaries had roughly 409,000 IRF stays. On average, the FFS Medicare program accounted for about 58 percent of IRF discharges.

As described in Chapter 9, our payment adequacy indicators for IRFs are positive.

**Beneficiaries' access to care**—In 2019, the number of IRFs decreased slightly from 1,170 to 1,152. Over time, the number of hospital-based and nonprofit IRFs has

fallen, while the number of freestanding and for-profit IRFs has mostly increased. In 2019, the average IRF occupancy rate remained at 67 percent, indicating that capacity is adequate to meet demand for IRF services. In addition, the number of Medicare cases per FFS beneficiary increased by 1.6 percent in 2019. That year, IRFs' average marginal profit was 19.4 percent for hospital-based IRFs and 40.2 percent for freestanding IRFs, indicating that IRFs with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

**Quality of care**—Measures of successful discharge to the community and hospitalizations within the IRF stay were steady or improved between 2015 and 2019.

**Providers' access to capital**—The parent institutions of hospital-based IRFs continue to have good access to capital (as discussed in Chapter 3). The continued expansion of a major freestanding IRF chain and freestanding IRFs' average total (all-payer) margin of 10.4 percent suggests that IRFs generally have good access to capital.

**Medicare payments and providers' costs**—Medicare FFS payments to IRFs continue to exceed their costs. In the five-year period between 2015 and 2019, the IRF Medicare margin remained above 13 percent. Although the aggregate Medicare margin decreased slightly in 2019 to 14.3 percent, it remained high. Medicare margins in freestanding and hospital-based IRFs were 24.6 percent and 2.1 percent, respectively. The coronavirus PHE has made 2020 an anomalous year in many respects, and it is impossible to predict with certainty the extent to which these effects will continue into 2021. Nevertheless, we expect the increase in revenue will more than offset cost growth over the period. Therefore, for 2021, we project an aggregate Medicare margin of 16 percent.

On the basis of these indicators, the Commission recommends a 5 percent reduction in the IRF base payment rate for fiscal year 2022. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded and (2) the Secretary conduct focused medical record reviews of IRFs.

## **Long-term care hospital services**

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods of time. To qualify for Medicare payment as an LTCH, a facility must meet Medicare's conditions



of participation for acute care hospitals and have an average length of stay of more than 25 days for certain Medicare patients. In 2019, Medicare spent \$3.7 billion on care provided in LTCHs. That year, about 82,000 FFS Medicare beneficiaries had about 91,000 LTCH stays, which accounted for about 56 percent of LTCH stays among all users.

CMS began a four-year phase-in of a dual payment-rate system for LTCHs in fiscal year 2016. When fully phased in, LTCHs will be paid the standard LTCH PPS rate for cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and will be paid a lower “site-neutral” rate for cases that do not. While policies effective during the coronavirus PHE have temporarily affected the complete transition to site-neutral rates for all LTCHs in 2021, ultimately, the extent to which LTCHs shift toward cases that qualify for the standard LTCH PPS rate will determine the industry’s financial performance under Medicare’s LTCH PPS. Our payment adequacy analysis must be interpreted in the context of the transition to the dual payment-rate system and its anticipated effects on our payment adequacy metrics. To assess the adequacy of standard payments under the LTCH PPS for cases meeting the LTCH criteria, some of our analyses focus on LTCHs treating a high share (more than 85 percent) of LTCH PPS-qualifying cases, consistent with the goals of the dual payment-rate system.

As described in Chapter 10, our payment adequacy indicators for LTCHs are generally positive or reflect expected changes under the new dual payment-rate system.

***Beneficiaries’ access to care***—In 2019, the number of LTCH facilities decreased by 3.5 percent, and the number of LTCH beds decreased by 3 percent, continuing the decline following the implementation of the dual payment-rate system. However, the average LTCH occupancy rate was 63 percent in 2019, suggesting that LTCHs have capacity in the markets they serve. From 2016 to 2019, the total number of Medicare cases in all LTCHs decreased by an average of about 10 percent annually. At the same time, LTCHs’ marginal profit averaged about 15 percent in 2019, indicating that LTCHs with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

***Quality of care***—Aggregate risk-adjusted rates of successful discharge to the community have declined, and all-condition hospitalizations within a stay have been

unchanged during the dual payment-rate phase-in period. Consistent with prior years, non-risk-adjusted mean rates of death in the LTCH and death within 30 days of discharge for all cases were stable.

***Providers’ access to capital***—LTCHs continued to alter their cost structures and referral patterns in response to the dual payment-rate system. Continued phase-in of site-neutral rates for nonqualifying cases, coupled with payment reductions to annual updates required by statute, have limited opportunities for growth in the near term and reduced the industry’s need for capital.

***Medicare payments and providers’ costs***—Aggregate margins for all LTCHs have been variable and negative during the phase-in of the dual payment-rate system because costs grew more than payments in most years between 2016 and 2019. In 2017, the first full year that all LTCHs received the blended site-neutral rates under the transition to the dual payment-rate system, aggregate Medicare margins fell to –2.2 percent and then increased to –0.5 percent in 2018. In 2019, margins fell again to –1.6 percent. As they have since 2017, LTCHs with a high share of cases that met the criteria to be paid the standard LTCH rates had positive margins, 2.9 percent in 2019, which is a reduction of 1.8 percentage points from 2018. We expect continued changes in admission patterns and cost structures of LTCHs in response to the full implementation of the dual payment-rate system in 2020 and 2021, but the waiver of some site-neutral payment rules to create additional inpatient capacity during the PHE has delayed full implementation. We project that LTCHs’ aggregate Medicare margin for facilities with more than 85 percent of Medicare discharges meeting the LTCH PPS criteria will be 2 percent in 2021.

On the basis of these payment adequacy indicators and in the context of recent changes in payment policy, the Commission recommends a 2 percent increase in LTCH payment rates for 2022. This update supports LTCHs in their provision of safe and effective care for Medicare beneficiaries meeting the LTCH PPS criteria for payment at the standard LTCH PPS rate.

## **Hospice services**

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare

coverage for conventional treatment of their terminal illness and related conditions. In 2019, more than 1.6 million Medicare beneficiaries (including more than half of decedents) received hospice services from 4,840 providers, and Medicare hospice expenditures totaled \$20.9 billion.

As described in Chapter 11, our payment adequacy indicators for hospice services are positive.

**Beneficiaries' access to care**—In 2019, the number of hospice providers increased by 4.3 percent, due largely to growth in the number of for-profit hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers. In the same year, the proportion of beneficiaries using hospice services at the end of life continued to grow, and length of stay among decedents increased. Between 2018 and 2019, the share of Medicare decedents who used hospice rose from 50.6 percent to 51.6 percent, the average length of stay among decedents rose from 90.3 days to 92.6 days, and the median length of stay was stable at 18 days. In 2018, hospices' marginal profit on Medicare FFS beneficiaries averaged roughly 16 percent, indicating that hospices with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

**Quality of care**—Hospices' performance on available process measures remained very high, although these measures are limited and are largely topped out (i.e., scores are so high and unvarying that meaningful distinctions in performance can no longer be made). Performance on a measure of visits in the last three days of life improved slightly. Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® were stable. However, an Office of Inspector General analysis of data from state survey agencies and accrediting organizations identified 313 hospice providers as poor performers in 2016 due to at least one occurrence of a serious deficiency or severe and substantiated complaint that year.

**Providers' access to capital**—Access to capital is a less important indicator of Medicare payment adequacy for hospice services because it is less capital intensive than most other health care sectors. However, continued growth in the number of for-profit providers (a 6.3 percent increase in 2019) and reports of strong investor interest in the sector suggest capital is available to these providers. Less is known about access to capital for nonprofit, freestanding providers, for which capital may be more

limited. Hospital-based and home health-based hospices have access to capital through their parent providers.

**Medicare payments and providers' costs**—Consistently high average Medicare margins indicate that Medicare FFS payments to hospice providers have continued to exceed hospices' average costs. The aggregate 2018 Medicare margin was 12.4 percent (similar to 12.5 percent in 2017), and the projected 2021 margin is 13 percent.

In addition to indicators of hospice payment adequacy, Chapter 11 also discusses the hospice aggregate cap, which limits the total payments a hospice provider can receive in a year in aggregate. If a provider's total payments exceed the number of patients treated multiplied by the cap amount, the provider must repay the excess to the Medicare program.

The aggregate cap functions as a mechanism that reduces payments to hospices with long stays and high margins. In 2018, about 16 percent of hospices exceeded the cap; their aggregate Medicare margin was about 22 percent before and 10 percent after application of the cap. These above-cap hospices had high average lengths of stay and high live-discharge rates and were disproportionately for-profit, freestanding, urban, small, and new entrants to the Medicare program. Unlike wage-adjusted Medicare payments, the hospice aggregate cap is not wage adjusted, resulting in an aggregate cap that is stricter in some areas of the country than in others.

On the basis of these payment adequacy indicators and analysis of the hospice aggregate cap, the Commission recommends that hospice payment rates for 2022 be held at their 2021 levels and that the aggregate cap be wage adjusted and reduced by 20 percent.

## **The Medicare Advantage program: Status report**

In Chapter 12, as we do each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2020, the MA program included over 4,000 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$317 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare



beneficiaries. We also provide updates on risk adjustment, risk coding practices, and the current state of quality reporting in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose among Medicare coverage options, including the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate, risk adjusted per enrollee, rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques to deliver more efficient care.

The Commission has emphasized the importance of encouraging all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from prior levels, which subsidized MA plans by providing payments substantially above FFS rates. The phase-in of MA payment policies from the Affordable Care Act (ACA) reduced the difference in Medicare spending between MA and FFS on a national average basis. However, aggregate plan payments under the ACA were similar to FFS levels for only one year before rising above FFS due to higher risk coding, an increasing share of MA enrollees in areas with payments above FFS spending, and quality bonus rules. Notwithstanding, over the past few years, plan bids have fallen in relation to FFS spending while MA enrollment continues to grow. Plans have improved efficiencies, leading to more competitive bids that enable MA plans to continue to increase enrollment by offering extra benefits that beneficiaries find attractive. The clear, strong trend suggests an opportunity for the Medicare program to share in MA efficiencies.

**Enrollment**—Between July 2019 and July 2020, enrollment in MA plans grew by 10 percent, or 2.1 million enrollees, to 24.4 million enrollees. About 43 percent of Medicare beneficiaries with Part A and Part B coverage were enrolled in MA plans in 2020, up from 40 percent in 2019.

**Plan availability**—Access to MA plans remains high in 2021, with most Medicare beneficiaries having access to many plans. Overall, 99 percent of Medicare beneficiaries

have access to an MA plan and 98 percent have an HMO or local preferred provider organization plan operating in their county of residence. The average beneficiary in 2021 has 32 available plans sponsored by 7 different parent organizations.

**Plan rebates**—In 2021, rebates used to provide additional benefits to enrollees are at a historic high of \$140 per enrollee per month. The average total rebates are 14 percent higher than in 2020. Plans can devote the rebate (including plans' allocation of administrative costs and profit) to lower cost sharing, lower premiums, or provide supplemental benefits.

**Plan payments**—In 2021, total Medicare payments to MA plans average an estimated 104 percent of FFS spending, an increase of 1 to 2 percentage points compared with 2020. The 2021 estimate incorporates about 3 percentage points of uncorrected coding intensity. Relative to FFS spending, quality bonuses in MA account for an estimated 2 to 3 percentage points of MA payments in 2021. Using plan bid data for 2021, and ignoring the impact of coding intensity, we estimate that MA payments would be 101 percent of FFS spending. Bid data also show that MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—are slightly higher relative to FFS than they were in recent years. MA benchmarks in 2021 averaged an estimated 108 percent of FFS spending (including quality bonuses), compared with 107 percent in 2020. Bids slightly decreased to 87 percent of FFS, a record low.

**Risk adjustment and coding intensity**—Medicare payments to MA plans are enrollee specific, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. Most claims in FFS Medicare are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses: Higher enrollee risk scores result in higher payments to the plan.

Our analysis for 2019 shows that higher diagnosis coding intensity resulted in MA risk scores that were more than 9 percent higher than scores for similar FFS beneficiaries. This estimate is higher than the prior year due to faster MA risk score growth relative to FFS risk score growth. By law, CMS must make an across-the-board reduction to

MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a larger reduction than the minimum required by law, the agency has never done so. The minimum adjustment for coding intensity will remain at 5.9 percent until risk adjustment incorporates MA diagnostic, cost, and use data. The Commission previously recommended that MA risk adjustment exclude diagnoses collected from health risk assessments, use two years of diagnostic data, and apply an adjustment for any residual impact of coding intensity to improve equity across plans and eliminate the impact of differences between MA and FFS coding intensity. This year, we highlight the impact of MA plans' use of medical chart reviews to increase risk scores (a coding practice that does not exist in FFS). Recent reports from the Office of Inspector General indicate that the majority of MA coding intensity may be due to chart reviews and health risk assessments.

**Quality in MA**—The Commission has previously reported its concerns with the MA star rating system and recommended improvements. The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA. With 43 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare is necessary for proper evaluation. The ability to compare MA and FFS quality and to compare quality among MA plans is also important for beneficiaries. Recognizing that the current quality program is not achieving its intended purposes and is costly to Medicare, in our June 2020 report we recommended a new value incentive program for MA that would replace the current quality bonus program.

**Future direction of MA payment policy**—Many indicators continue to point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and historically high extra benefits. However, some MA policies are in need of immediate improvement. The Commission is assessing an alternative MA benchmark policy that would improve equity and efficiency in the MA program.

Despite the relative efficiency of MA plans in providing Part A and Part B benefits, in 2021, aggregate MA payments (including rebates that finance extra benefits) are about 4 percent higher than expected FFS expenditures

for similar beneficiaries, an increase of more than 1 percentage point from last year. In setting payment policy in the FFS sector, the Commission consistently strives to encourage providers to deliver care efficiently while maintaining beneficiary access to good quality care. However, given the level of overutilization in FFS and other factors not discussed in this chapter—such as the volume-inducing effects of traditional FFS Medicare, which are compounded by Medigap's effect of insulating beneficiaries from true health care costs and inappropriate spending owing to fraud and waste—using payment parity between MA and FFS Medicare as a benchmark prevents policymakers from using any efficiencies generated by the MA program to reduce program spending. Consistent with the original incorporation of full-risk private plans in Medicare in 1982, in which private plan payments were set at 95 percent of FFS payments, we expect plans to be more efficient. In the future, Medicare may be able to share in some of those efficiencies.

## **The Medicare prescription drug program (Part D): Status report**

In 2020, the Part D program paid for outpatient prescription drug coverage for more than 47 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing to nearly 13 million individuals with low income and assets. The 2020 benefit year was extraordinary due to the coronavirus pandemic and its toll on Medicare beneficiaries and health care providers. However, Medicare beneficiaries experienced comparatively less disruption of access to medicines than to other types of health care services; only 7 percent had to forgo medications compared with 36 percent for medical services.

In 2019, Part D program expenditures totaled \$102.3 billion. Enrollees paid \$13.9 billion of that amount in plan premiums for basic benefits, plus an additional \$16.7 billion in cost sharing, and additional amounts in premiums for enhanced benefits. Part D has been a success in many respects. It has improved beneficiaries' access to prescription drugs. Generic drugs account for nearly 90 percent of the prescriptions filled. More than 9 in 10 Part D enrollees report they are satisfied with the program.

However, changes to Part D's benefit design combined with trends in drug spending have eroded plans' incentives

for cost control. Over time, a growing share of Medicare's payments to plans have taken the form of cost-based subsidies rather than capitated payments, and the financial risk that plans bear has declined markedly. Last year, the Commission recommended major changes to the Part D benefit design and Medicare's subsidies to restore the role of risk-based, capitated payments that was present at the start of the program and to provide drag on drug price increases. Separately, we are concerned that the LIS has features that limit premium competition among plans that serve low-income beneficiaries.

Nearly 300 organizations sponsor Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. Most large plan sponsors are vertically integrated with their own pharmacy benefit manager (PBM), and many also operate mail-order and specialty pharmacies. Formularies remain plan sponsors' most important tool for managing drug benefits. Generally, pharmaceutical manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. Plan sponsors and PBMs have negotiated rebates that have grown as a share of Part D spending. However, the wide gap between spending before and after rebates raises concerns about the accuracy of Part D's risk adjustment system.

***Enrollment in 2020 and benefit offerings for 2021***—In 2020, 74.6 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 1.9 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. The remaining 23.5 percent were divided roughly equally between those who had creditable drug coverage from other sources and those with no coverage or coverage less generous than Part D.

Between 2019 and 2020, enrollment in stand-alone prescription drug plans (PDPs) declined slightly, while enrollment in Medicare Advantage–Prescription Drug plans (MA–PDs) expanded to 47 percent of enrollees.

For 2021, beneficiaries have a broad choice of plans, ranging from 25 PDPs in Alaska to 35 PDPs in Texas, along with many MA–PDs in most areas. Most plans use a five-tier formulary that uses differential cost sharing between preferred and nonpreferred drugs, as well as a specialty tier for high-cost drugs. For 2021, the \$33.06 base beneficiary premium increased by 1 percent, but individual plans' premiums can vary substantially. In 2021, 259

premium-free PDPs are available to the 27 percent of Part D enrollees who receive the LIS, and all regions have at least 5 premium-free PDPs for LIS enrollees.

***Part D program costs***—Between 2007 and 2019, Part D program spending increased from \$46.2 billion to \$88.4 billion. Medicare's reinsurance (which covers 80 percent of spending in the catastrophic phase of the benefit) continues to be both the largest and fastest growing component of program spending. As a result, between 2007 and 2019, the portion of the average basic benefit paid to plans through the capitated direct subsidy fell from 54.7 percent to 15.3 percent. In 2019, Part D saw the largest increase ever in beneficiaries without the LIS reaching the benefit's catastrophic phase (high-cost enrollees). In 2019, high-cost enrollees accounted for 64 percent of Part D spending, up from about 40 percent before 2011. Overall, our index of Part D prices declined in 2019, owing to increased generic competition. However, in classes dominated by brand-name drugs or biologics, prices continued to rise. In 2019, over 483,000 enrollees (11 percent of high-cost enrollees) filled a prescription for which a single claim was sufficient to meet the out-of-pocket threshold, up from just 33,000 in 2010.

***Beneficiary access and quality in Part D***—Data from CMS audits and Part D appeals processes suggest that beneficiaries may be less likely to encounter access issues for most drugs than in previous years. However, among beneficiaries without the LIS, high cost sharing for expensive therapies may be a barrier to access. In 2021, the average star rating among Part D plans increased somewhat for PDPs and decreased for MA–PDs. While average star ratings for MA–PDs continue to exceed those of PDPs, the trend among MA–PD sponsors of consolidating contracts leads us to question the validity of MA–PD ratings. It is not clear that current quality metrics help beneficiaries make informed choices among their plan options.

## **Telehealth in Medicare after the coronavirus public health emergency**

During the coronavirus PHE, the Congress and CMS have temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and reduce their risk of exposure to COVID-19. Hospitals, physicians, and other providers have responded by rapidly adopting telehealth to provide continued access to medical care for their patients.

Without legislative action, many of the changes will expire at the end of the PHE.

Although temporary telehealth expansions affect virtually all settings of care, most of the changes affect the services paid under the physician fee schedule (PFS). Before the PHE, Medicare paid for a limited number of telehealth services and only if they were provided to beneficiaries in a clinician's office or facility in a rural area. In addition, most telehealth services were paid at the lower PFS rate used to pay clinicians providing care in facilities (the facility-based rate), rather than the higher rate used to pay office-based clinicians (the nonfacility rate), because the practice expenses associated with furnishing telehealth services were presumed to be lower. During the PHE:

- Clinicians may bill for telehealth services provided to Medicare beneficiaries in any location, including their homes and in urban as well as rural areas.
- CMS has added over 140 PFS services to the list of services it will pay for when delivered through telehealth. Clinicians can bill for some of these services if they are provided using audio-only interaction, and CMS also added new codes for audio-only evaluation and management visits.
- CMS pays the same rate it would have paid if the service had been provided in person.
- Clinicians may reduce or waive beneficiaries' cost-sharing obligations for telehealth services.

CMS made these changes quickly out of necessity, and we applaud the agency for acting rapidly to preserve access to care during the PHE. We expect these telehealth expansions will remain in place throughout the PHE. There is ongoing debate on whether the expansions should be made permanent.

In Chapter 14, a policy option for expanded coverage of Medicare telehealth policy after the PHE is over. Under this policy option, policymakers should temporarily continue the following telehealth expansions for a limited

duration of time (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on access, quality, and cost, and they should use that evidence to inform any permanent changes. During this limited period, Medicare should temporarily:

- pay for specified telehealth services provided to all beneficiaries regardless of their location,
- cover certain telehealth services in addition to services covered before the PHE if there is potential for clinical benefit, and
- cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.

After the PHE ends, Medicare should return to paying the fee schedule's facility rate for telehealth services and collect data on the cost of providing those services. In addition, providers should not be allowed to reduce or waive cost sharing for telehealth services after the PHE. CMS should also implement other safeguards to protect the Medicare program and its beneficiaries from unnecessary spending and potential fraud related to telehealth, including:

- applying additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians,
- requiring clinicians to provide an in-person face-to-face visit before they order high-cost durable medical equipment or high-cost clinical laboratory tests, and
- prohibiting "incident to" billing for telehealth services provided by any clinician who can bill Medicare directly.

Chapter 14 also describes CMS's existing authority to offer telehealth flexibilities to clinicians participating in advanced alternative payment models, such as accountable care organizations. ■

